portion carefully removed with the scissors from each, and then united by a catgut suture carried through them with a fine round needle about one millimetre from their extremities. The tension required to bring them together was very great, and made Professor Langenbeck fear an unsuccessful result. The wound was dressed antiseptically, and the arm put on an obtuse-angled splint. On December 9 the wound had healed. On December 14 the induced current caused distinct contraction of the extensors of the hand and fingers, and there was a slight power of voluntary movement. On December 20 the latter was well marked; and on January 14, 1880, under daily treatment with the induced current, the patient could extend his fingers completely, and raise the hand to a level with the forearm, but not further.

In his remarks on this interesting case, Professor Langenbeck observed that, owing partly to the great tension of the nerve-ends, and partly to the fact that no nerve-tissue could be found in the portions removed by the scissors, he had very little hope that continuity would be restored. Gluck, however ("Experimentelles sur Frage Nervennaht und der Nervenregeneration"—*Virchow's Archiv*, Bd. 78, 1878), has shown that the divided ends of a nerve unite by means of an intermediate substance consisting of granulation tissue in which spindle-cells develop and send out processes which unite the axis-cylinders of the nerve-ends together, and finally become converted into true nerve-fibrils. Probably some such intermediate substance was formed in Professor Langenbeck's case. The radial nerve has been sutured in two other cases: by Létiévant unsuccessfully, and by Esmarch (sixteen months after the injury) with almost perfect restoration of the functions and sensibility of the hand. On the whole, Professor Langenbeck does not consider the results of operation for nerve suture hitherto very successful. In all the published cases except the present there were severe pains in the course of the sutured nerves, and the wound did not heal by first intention, as here, or went through a long period of suppuration. Most of the former cases were sutured with silver wire or silk. Langenbeck strongly recommends catgut: it irritates less, can remain *in situ* permanently, and can be carried through the nerve-ends themselves. The absence of bulbous swelling in the divided nerve-ends has been already noticed. Professor Langenbeck explains this deviation from the rule in his case by the radial nerve having probably suffered a slow, and not a sudden, process of division during the sloughing of the bruised tissue of the arm. His case is further peculiar in the fact that the motor or centrifugal functions of the nerve were restored before the centripetal or sensory. The back of the hand remained anæsthetic when the extensor movements of the hand and fingers were completely restored.—*Med. Times and Gaz.*, May 29, 1880.

OPHTHALMOLOGY AND OTOLOGY.

Diabetic Hypermetropia.

The ocular complications of diabetes are well known, and diabetic cataract, retinal hemorrhages, optic neuritis, and paralysis both of the intrinsic and external muscles of the eye are often met with. Dr. LANDOLT contributes an article to *El Siglo Medico*, of Madrid, and calls attention to a symptom which has hitherto attracted but little attention. A woman, aged sixty-one, consulted him with reference to her sight. Long vision had always been good, and she had also seen well at a short distance with the aid of glasses, which, however, had now become inefficient. Upon examination he found that she had a hypermetropia of 1.25 dioptrics (= old No. 30), visual acuity 0.5, presbyopia 5 dioptries (old 8). With these glasses she saw well, so that the change of the sight depended upon a change in the refraction, rather than upon an alteration of the visual acuity. This change had occurred after a fall six months before, and in consequence of which she had suffered from pains in the back and hips, as well as from glycosuria. At the time of consultation there were 229.4 grammes of sugar in 2630 cubic centimetres of urine analyzed. The specific gravity was 1040. Fifteen days later the hypermetropia was only 0.75 dioptrics (old 50), and after four months 0.25 (old 156). At the end of five months it had entirely disappeared. The patient had become emmetropic, as before, and had returned to her old glasses. Coincidently with this increase of the refraction the quantity of sugar in the urine diminished, and when the hypermetropia had become 0.75 dioptrics it had disappeared altogether. The author attributes this diminution of refraction (hypermetropia) to the infiltration of sugar into the vitreous humor, in consequence of which the index of refraction is increased, whilst the general refraction of the eye is lessened.—*Lancet*, April 17, 1880.

A Case of Gonorrhœal Ophthalmia, with some novel suggestions as to Treatment.

Mr. George Critchett, Consulting Surgeon to the Royal London Ophthalmic Hospital, in a communication to the *Lancet* (April 3, 1880), says:—

As a general rule I have been unwilling to encumber medical literature with isolated cases, but I am disposed to think that exceptions may occasionally occur in which, either from extreme rarity or from the initiation of some new method of treatment, or, at any rate, a method very rarely employed and but little known, some fresh starting point may be established. Acting on this principle, and influenced by these motives, I am induced to bring the following case before the notice of the profession:—

Louisa C——, aged two and a half years, was brought to me at the Middlesex Hospital on the 15th of May, 1878. Her left eye presented all the appearances of acute gonorrhœal ophthalmia, and the collateral circumstances confirmed this diagnosis, as the child had a profuse yellow discharge from the vagina, with considerable swelling and irritation of the mucous canal. The lids were of a bright red colour and much swollen, and so densely infiltrated that even when the child was placed under the influence of an anæsthetic it was found impossible to separate them so as to ascertain the condition of the cornea. Yellow, and rather thick matter was exuding from between the lids.

Judging from past experience, seeing the extreme acuteness and severity of the symptoms, the difficulty in separating the lids or exposing the cornea, and the impossibility of getting any solution into contact with the conjunctival surface, I relinquished all hope of saving the sight. I have never in the course of my experience known such a condition eventuate otherwise than in the total destruction of the eye. Under these circumstances I determined to adopt a somewhat heroic and novel proceeding, and one that has not, I believe, been published. I passed a small silver director under the upper lid as far as the edge of the orbit, against which I kept it pressed; and then, with a small, sharp-pointed bistoury, I completely divided the lid perpendicularly as far as the margin of the eyebrow. In order more completely to uncover the cornea, I separated the two angles of the divided tarsus, and fixed them with fine sutures to the skin of the eyebrow. The cornea looked steamy, but not ulcerated, and was buried in chemosed conjunctiva. The immediate effect of this proceeding was to diminish the redness and swelling of the lids and conjunctival membrane and completely to expose the surface.